

Ship To:  
Name:  
Address:  
  
Contact Person:

## Request for Anti-Tuberculosis Medications

### Kansas TB Control and Prevention Program

**PLEASE PRINT CLEARLY**

Monitor Date	Staff Initial	Patient HAWK # or Name	DOB	KDHE Use Only		Initial	Continuation	Restart	INH 100 mg x 100 tabs		INH 300 mg x 30		lot # / pharmacy #		Pyridoxine (B6)		lot # / pharmacy #		KDHE Use Only
				Induration	Xray														

**Additional medications not listed above are to be ordered on the "Request for Anti-Tuberculosis Medications Additional Medications Form".**

**MEDICATIONS WILL BE LIMITED TO ATS/CDC RECOMMENDED TREATMENT REGIMES**

**Submit order by any of the following means:**

mail: KDHE TB Control Program, 1000 SW Jackson, Suite 210, Topeka, KS 66612-1274

fax: 785-291-3732